Company of Florida
MS Life Insurance Company
Life of Mississippi Insurance Company

CENTRAL PROCESSING SERVICES
INITIAL CREDIT DISABILITY CLAIM FORM

A. CLAIMANT'S STATEMENT FOR ACCIDENT OR SICKNESS CLAIM — **PLEASE PRINT**

NAME OF FINANCIAL INSTITUTION (WHERE PAYMENT IS TO BE MADE)	CLAIMANT'S E-MAIL ADDRESS (IF APPLICABLE)

FULL NAME OF CLAIMANT (LAST, FIRST, MIDDLE INITIAL)	DATE OF BIRTH / /	AGE

STREET ADDRESS/APT. #	CITY	STATE	ZIP CODE	TELEPHONE NUMBER ( )

WHAT IS YOUR USUAL OCCUPATION	DESCRIBE YOUR USUAL JOB DUTIES

WERE YOU EMPLOYED WHEN DISABILITY BEGAN ☐ Yes ☐ No	IF YES, DATE YOU BECAME UNEMPLOYED / /	GIVE EXACT REASON FOR YOUR UNEMPLOYMENT

ARE YOU RETIRED ☐ Yes ☐ No	IF YES, DATE RETIRED / /	REASON FOR RETIREMENT

NAME, ADDRESS AND PHONE NUMBER OF THE EMPLOYER YOU WERE WORKING FOR WHEN YOUR DISABILITY BEGAN (IF UNEMPLOYED WHEN DISABILITY BEGAN, STATE NAME, ADDRESS AND PHONE NUMBER OF LAST EMPLOYER)

DISABILITY CAUSED BY ☐ Accident ☐ Sickness	DATE ACCIDENT HAPPENED OR DATE SICKNESS BEGAN / /	DESCRIBE YOUR SICKNESS OR INJURY

ON WHAT DATE WERE YOU FIRST TREATED BY A PHYSICIAN FOR THIS SICKNESS OR INJURY / /	GIVE NAME OF PHYSICIAN	TELEPHONE NUMBER ( )

LIST ALL DOCTORS, CLINICS, AND HOSPITALS WHICH TREATED YOU IN THE **PAST FIVE YEARS, FOR ANY INJURY, ILLNESS OR GENERAL CHECK-UPS** -- INCLUDE COMPLETE ADDRESS AND PHONE NUMBER (ATTACH A SEPARATE LIST IF ADDITIONAL SPACE IS NEEDED)

ARE YOU NOW RECEIVING OR HAVE YOU APPLIED FOR: **(IF YES, ATTACH A COPY OF THE AWARD LETTER)** SOCIAL SECURITY DISABILITY ☐ Yes ☐ No OTHER DISABILITY BENEFITS	DATE OF ENTITLEMENT / /

GIVE FIRST DATE YOU DID NOT WORK BECAUSE OF THIS SICKNESS OR INJURY / /	DATE YOU RETURNED TO WORK PART-TIME / /	DATE YOU RETURNED TO WORK FULL-TIME / /	# OF HOURS PER DAY

IF YOU HAVE RETURNED TO WORK PART-TIME, DESCRIBE THE DUTIES YOU ARE ABLE TO PERFORM

I AUTHORIZE any employer, physician, hospital, clinic, other medical or medically related facility, the Medical Information Bureau, Inc., consumer reporting agency, insurance or reinsuring company, insurer, law enforcement agency, fire department, Social Security Administration, Internal Revenue Service, or other organization, or person having any records, data or information concerning this claim to furnish such record, data or information to the insurance company issuing my policy as requested. I understand that in executing this authorization, I waive the right for such information to be privileged as it pertains to the processing or investigation of my claim(s). A photocopy of this authorization shall be considered as effective and valid as the original.

I understand and acknowledge that this authorization extends to all or any part of the records being requested, which may include treatment for physical and mental illness, alcohol/drug abuse, and/or HIV/AIDS test results or diagnosis and treatment. I expressly consent to the release of information as designated above.

The above information is true and correct. If in fact the furnished information is false thereby inducing payment of claim and the insurance company issuing my policy determines that the incorrect information constitutes an aiding and abetting the filing of a fraudulent claim, the insurance company issuing my policy may furnish the above information to the appropriate state authorities to be used in its discretion as the basis for action authorized under applicable state law. In addition, I agree any statements made on this or any other form found to be false, shall give the insurance company issuing my policy the right to void my policy.

This authorization shall be valid for the duration of the claim.

WARNING: *Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claims containing any materially false information or conceals, for the purposes of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and may subject such person to criminal and substantial civil penalties.

CLAIMANT'S SIGNATURE	SOCIAL SECURITY NUMBER	DATE
X	— —	/ /

CA residents only: For your protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

DC residents only: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FL residents only: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

KY residents only: Any person who knowingly and with intent to defraud any insurance company, or other person files claim for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. **HIGH LIMIT AD -** No statements made by the applicant may be changed without his written consent.

NJ residents only: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NM residents only: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

OK residents only: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

TX residents only: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

VA residents only - *This notice is not applicable to life and health insurance.

B. EMPLOYER'S STATEMENT (MUST BE FULLY COMPLETED) PLEASE PRINT

I am the employer of the named claimant, and for the purpose of furnishing information to the named Insurance Company to induce payment of claim of said employee, do certify as follows.

NAME OF EMPLOYEE	DATE HIRED	DATE LAST WORKED PRIOR TO DISABILITY
	/ /	/ /

EMPLOYEE WAS ABSENT FROM JOB DUE TO	EMPLOYEE'S OCCUPATION/JOB TITLE
☐ Accident ☐ Sickness	

HAS EMPLOYEE RETURNED TO WORK	WHAT DATE DID EMPLOYEE RESUME PARTIAL DUTIES	WHAT DATE DID EMPLOYEE RESUME FULL DUTIES
☐ Yes ☐ No	/ /	/ /

NAME OF EMPLOYER	TELEPHONE NUMBER	FAX NUMBER
	( )	( )

STREET ADDRESS	CITY	STATE	ZIP CODE

COMPLETED BY (PRINT NAME)	SIGNATURE	POSITION	DATE
	X		/ /

C. DOCTOR'S STATEMENT (TO BE FURNISHED WITHOUT EXPENSE TO THE INSURANCE COMPANY) PLEASE PRINT

PATIENT'S FULL NAME	DATE OF BIRTH	AGE
	/ /	

DIAGNOSIS CODE(S)	CURRENT DIAGNOSIS
☐ ICD-9 _____ ☐ CPT _____ ☐ DSM III _____	

IS CONDITION DUE TO PREGNANCY	IF YES, DESCRIBE COMPLICATIONS	ESTIMATED DATE OF DELIVERY
☐ Yes ☐ No		/ /

WHEN DID SYMPTOMS FIRST APPEAR	WAS DISABILITY CAUSED BY AN ACCIDENT	IF YES, DATE OF ORIGINAL ACCIDENT
/ /	☐ Yes ☐ No	/ /

IF YES, DESCRIBE ACCIDENT

HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION	GIVE DATES OF TREATMENT FOR SIMILAR CONDITION (MM/DD/YY)
☐ Yes ☐ No	

DESCRIBE SAME OR SIMILAR CONDITION

GIVE NAMES, ADDRESSES, AND PHONE NUMBERS OF OTHER TREATING PHYSICIANS (ATTACH ADDITIONAL SHEET IF NECESSARY)

DATES OF TREATMENT	FREQUENCY OF VISITS
FIRST VISIT / / LAST VISIT / / NEXT VISIT / /	☐ Weekly ☐ Monthly ☐ Other (specify). _____

HAS PATIENT BEEN HOSPITALIZED	NAME OF HOSPITAL
☐ Yes ☐ No IF YES, FROM / / THROUGH / /	

STREET ADDRESS	CITY	STATE	ZIP CODE	TELEPHONE NUMBER
				( )

DID PATIENT HAVE SURGERY	IF YES, DESCRIBE SURGERY	DATE PERFORMED
☐ Yes ☐ No		/ /

IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION	IF PATIENT IS STILL UNDER YOUR CARE, GIVE ESTIMATED DATE WHEN PATIENT WILL RESUME WORK	IF NOT, GIVE DATE PATIENT WAS RELEASED TO RESUME WORK
☐ Yes ☐ No	/ /	/ /

GIVE EXACT DATES OF TOTAL DISABILITY (UNABLE TO WORK)	GIVE EXACT DATES OF PARTIAL DISABILITY
FROM / / TO / / ☐ His/Her Occupation ☐ Any Occupation	FROM / / TO / / ☐ His/Her Occupation ☐ Any Occupation

IN YOUR EXPERT OPINION, HOW WOULD YOU QUALIFY THIS PATIENT	IF TEMPORARILY DISABLED, HOW MUCH LONGER DO YOU EXPECT THE PATIENT TO BE DISABLED
☐ Permanently Disabled ☐ Temporarily Disabled ☐ Non-Disabled	☐ 1-2 mos. ☐ 3 mos. ☐ 6 mos. ☐ Longer than 9 mos. ☐ Undetermined

PHYSICAL IMPAIRMENTS (AS DEFINED IN FEDERAL DICTIONARY OF OCCUPATIONAL TITLE)

- ☐ Class 1 - No limitation of functional capacity; capable of heavy work; no restrictions. (0-10%)
- ☐ Class 2 - Medium manual activity. (15-30%)
- ☐ Class 3 - Slight limitation of functional capacity; capable of light work. (35-55%)
- ☐ Class 4 - Moderate limitation of functional capacity; capable of clerical/administrative (sedentary) activity. (60-70%)
- ☐ Class 5 - Severe limitation of functional capacity; incapable of minimum (sedentary) activity. (75-100%)

PROGNOSIS/COMMENTS (HAS PATIENT PROGRESSED)

"I hereby certify that the above described information is based upon reasonable medical probability, and is true and correct to the best of my knowledge and belief."

STREET ADDRESS	CITY	STATE	ZIP CODE	TELEPHONE NUMBER	FAX NUMBER
				( )	( )

ATTENDING PHYSICIAN'S NAME (PLEASE PRINT)	ATTENDING PHYSICIAN'S SIGNATURE	MEDICAL ID NUMBER	DEGREE	DATE
	X			/ /

FORM MUST BE FULLY COMPLETED AND SIGNED OR STAMPED BY DOCTOR'S OFFICE

D. CREDITOR'S INFORMATION (ATTACH A PHOTOCOPY OF POLICY/CERTIFICATE) PLEASE PRINT

POLICY/CERTIFICATE # (INCLUDE PREFIX)	DATE OF ISSUE	TERM IN MONTHS	AGENT CODE	BRANCH NO.	CLAIM NUMBER

WAS HEALTH QUESTIONS USED ☐ Yes ☐ No **IF YES, ATTACH A COPY OF COMPLETED APPLICATION.**

ACCOUNT # / LOAN #	DUE DATE	POLICY EXPIRES	A&H COVERAGE	FORM # OF POLICY/CERTIFICATE
	/ /	/ /	☐ Retro _____ Days ☐ Elimination _____ Days	

WAS THIS LOAN REFINANCED	PREVIOUS LOAN #	PREVIOUS POLICY # / CERTIFICATE #
☐ Yes ☐ No		

DATE OF ISSUE	EXPIRATION DATE	AMOUNT DUE ON DATE OF DISABILITY	PREVIOUS MONTHLY BENEFIT	PREVIOUS TERM
/ /	/ /	$	$	

MONTHLY BENEFIT	NUMBER OF DAYS CLAIMED	NAME OF DEALER OR BRANCH WHERE INSURANCE WAS PURCHASED
$		

FIRST BENEFICIARY/CREDITOR	TELEPHONE NUMBER	FAX NUMBER
	( )	( )

STREET ADDRESS	CITY	STATE	ZIP CODE	IS THIS A NEW ADDRESS
				☐ Yes ☐ No

NAME OF PERSON COMPLETING THIS SECTION (PLEASE PRINT)	SIGNATURE	DATE
	X	/ /